

Communicable Disease

UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health

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Why patients complete TB therapy – according to the patients and according to their case managers

Non-adherence with anti-tuberculosis treatment has been identified as a major factor in treatment failure, relapse, and the emergence of drug resistance. Ensuring that nursing case management and clinical services provide care that promotes adherence is a primary goal of the TB Division. Recently, the Tuberculosis Surveillance Area (TSA) nurses and the Boston Public Health Commission conducted a study to determine which factors were important to patients in completing therapy. These findings were then correlated with the factors that the case managers (local board of health nurses assigned to the TB cases) felt were important.

Patients rated the importance of 25 factors in assisting them with completion of therapy. They pertained to clinical services and to attitudes and beliefs known to affect adherence. Trained surveyors administered patient questionnaires. After completion of the patient questionnaire, a comparable questionnaire was mailed to the patient's case manager to rate the importance of the same factors. Forty percent (73/183) of the patients and eighty-eight percent (64/73) of the case managers completed the questionnaires.

Patients rated 'respect from providers' as the most

important factor in treatment completion. Other frequently cited factors included: free medications, physician involvement, desire to be cured, feeling they had no choice, protection of their privacy, family desires, patient education, outreach educator involvement and directly observed therapy (DOT). The following three factors were cited by patients, but not identified by the case managers: DOT, family desires and patients feeling they had no choice. Through open-ended questions, patients and case managers agreed the following were the most important factors: family support, outreach educator involvement, DOT, home visits made by the nurse and/or outreach educator, teamwork of the health care providers, and their own personal motivation for cure. Patients and case managers agreed the following were the most difficult factors in treatment completion: taking the medication (duration, quantity, side effects, etc.), accepting the diagnosis, being available for DOT, feeling of isolation/being shunned by friends, and ease of accessing transportation to clinic.

We thank all the patients and case managers who took the time to complete the survey. We hope the survey results provide useful feedback to health departments and suggests ways to assist patients in completing treatment. The survey results underscore the importance of research to develop new treatment modalities that will decrease both the duration of treatment and side effects. Showing patients the utmost respect is essential to treatment completion and achieving the goal of TB elimination.

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Refrigerated Vaccine Storage: Colder is Not Better

There might be a problem in your office that could affect the stability and efficacy of vaccines, the temperature at which you store your vaccines. Many people believe that as long as vaccines are in a cold refrigerator, everything is fine. This is not true! The proper storage temperature range (35°F to 46°F or 2°C to 8°C) must be maintained and monitored by checking and recording the temperatures on a log sheet ***at the beginning and end of each work day.***

As part of routine quality control, the Massachusetts Immunization Program (MIP) has conducted more than 300 vaccine management assessments at provider offices over the past three years. It has been found that 13% of these providers are

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Epidemiology

Summary of West Nile Virus in Massachusetts

West Nile (WN) virus infection is caused by WN virus, a flavivirus previously found only in Africa, Eastern Europe, Australia, and West Asia. Mild infections are common and include fever, headache, and body aches, often with skin rash and swollen lymph glands. Severe headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, occasional convulsions, paralysis, meningitis, encephalitis and occasionally death indicate more severe infection. Notable clinical illness with WN virus infection occurs in about 2-5% of exposed individuals. West Nile virus infection mortality ranges from 3% to 15% of hospitalized cases (higher rates among the elderly.)

An outbreak of WN virus infection, which is a mosquito-transmitted, was identified for the first time in North America in New York during the summer of 1999, causing illness and death in people, birds, and horses. Other states known to be affected in 1999 were New Jersey, Connecticut, and Maryland.

In the spring of 2000, the Massachusetts Department of Public Health (MDPH) began conducting statewide surveillance for WN virus. Birds, mosquitoes, human and horse specimens were tested at the State Laboratory Institute (SLI) in Jamaica Plain, Massachusetts. Also, the MDPH informed health care providers, veterinarians and local boards of health about WN virus disease testing and prevention.

In late July 2000, WN virus was isolated from an adult dead crow found on July 22nd near Willow Pond in Jamaica Plain. By October 1st, more than 210 birds tested positive for WN virus in Massachusetts.

After detecting WN virus in birds in Massachusetts, the MDPH implemented active surveillance for human cases of encephalitis and meningitis and began screening suspect cases for WN virus infection. Suspect cases include patients with fever and clinical evidence of encephalitis, meningitis or meningoencephalitis (not of bacterial etiology), with or without other neurologic signs, symptoms, or rash. As of October 1st, more than 200 human specimens were tested for WN virus infection, but no human infection was documented.

As of October 1st, one (1) horse from Middlesex County, with symptom onset on August 26th, and 4 pools of mosquitoes collected in Suffolk and Norfolk Counties have tested positive for WN virus.

For a list of prevention measures, refer to the *West Nile Virus Encephalitis Fact Sheet* and the *Steps You Can Take To Prevent West Nile Virus Encephalitis* information sheet on the MDPH website at www.state.ma.us/dph/. For a detailed and comprehensive summary of the WN virus outbreak in the United

States, visit the USDA's Veterinary Services website at www.aphis.usda.gov/vs/ep/WNV/summary.html. Additional information can also be found on the CDC website at www.cdc.gov/.

Tularemia on Martha's Vineyard

Since early July, the Massachusetts Department of Public Health (MDPH) has been investigating a cluster of tularemia cases among full- and part-time residents of Martha's Vineyard. Tularemia, sometimes referred to as "rabbit fever" after its most common reservoir, is a relatively rare zoonotic disease caused by the bacterium *Francisella tularensis*. The disease can be transmitted from direct or indirect contact with numerous mammals, the bites of ticks or deer flies, the consumption of contaminated food or water, or inhalation of the infecting organism. Clinical presentation will vary depending on the route of transmission and the infecting strain. During this most recent outbreak on the Vineyard, the majority of cases (64%) have had lung involvement.

Tularemia has been reported sporadically on Martha's Vineyard since rabbits from the west were introduced sixty years ago. Between 1990 and 1999, 17 cases of tularemia were reported to MDPH, with the majority coming from the Cape and Islands region.

On July 5th, MDPH was notified of two suspect cases of pneumonic tularemia occurring among residents of Martha's Vineyard and by mid-July three additional suspect cases were reported. At that time, MDPH notified hospital infection control practitioners and local boards of health on Martha's Vineyard, Nantucket and Cape Cod, as well as all medical providers on both Islands, of the cluster of tularemia cases. On July 18th, MDPH requested assistance from the Centers for Disease Control and Prevention (CDC) in investigating the cluster. Officers from the Epidemiologic Intelligence Service (EIS) traveled to Massachusetts, where they interviewed all cases and attending physicians, and performed retrospective case finding on Cape Cod and the Islands. Environmental samples were also taken. Results from this initial investigation did not uncover any common source of infection; however, it appeared that persons recently involved in outdoor occupations, such as landscapers or construction workers, were at an increased risk.

By mid-August, MDPH was investigating six confirmed pneumonic tularemia cases. Because at this time two of the confirmed cases had occurred in part-time residents of Martha's Vineyard who had sought medical care outside of the Vineyard, MDPH notified all emergency room physicians statewide of the tularemia cluster. At the end of August, MDPH issued a public health advisory to all Martha's Vineyard residents and visitors

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STD Education Efforts

The Division of STD Prevention (DSTDP) has renewed its commitment to educating HIV service providers about sexually transmitted diseases. A recent survey, sponsored by the Massachusetts HIV Prevention Planning Group (MPPG), conducted by Abt Associates, indicated that HIV service and prevention program providers wanted to know more about STDs and how to link with STD prevention services, with particular interest in partner notification services and how they might participate in the process of notifying partners.

Course development was overseen and managed by Christine Burke, the coordinator of education and policy development for the DSTDP. Lisa Gurland, RN, PsyD, of the Bureau of Communicable Disease Control, helped at each step in the process. Ms. Burke worked with division managers and several front line supervisors (people who oversee field case investigation services) to develop curricula.

The first course in the series is an Overview of Sexually Transmitted Diseases; a lecture course with generous time allotted for questions. The second course covered STD Prevention Services. This is a mix of lecture and skills building, with an introduction to client-centered counseling as practiced in the STD clinics. The third course is focused on skills building for counseling and for partner elicitation interviews.

Staff of the HIV/AIDS Bureau reviewed the curricula. The draft curricula were presented to staff of the Boston Public Health Commission (BPHC), who had requested such training for its managers and outreach workers. THE BPHC HIV/AIDS service managers then arranged with DSTDP to pilot the courses.

THE DSTDP gave a pilot version of all three courses to the HIV/AIDS service managers of the BPHC. Evaluations were favorable. Each of the courses were then provided to the outreach workers under contract with the BPHC. A more in-depth debriefing with all parties will be scheduled to review evaluations and see what modifications need to be made to ensure that the education requested is being provided. The curricula and the associated teaching materials will then be produced in quantity and the entire DSTDP staff will be trained. That way, we can diversify the faculty for these courses and be better able to offer them across the state. The courses will be advertised through MPPG meetings and quarterly HIV/AIDS contract manager's meetings. An evaluation will be conducted at each training. Every evaluation will also include input about what additional information providers need, so that we can continually meet needs.

Vaccine Storage continued from page one

storing refrigerated vaccines inappropriately at freezing temperatures. For most vaccines requiring refrigeration, freezing destroys the antigen. When vaccine is damaged due to exposure to freezing temperatures, the vaccine efficacy may have been affected. Therefore, sites that have had vaccine storage problems receive letters recommending that all individuals immunized with damaged vaccine be evaluated and revaccinated, if indicated.

In addition to vaccines, other biologicals have storage temperature ranges indicated on their package inserts. If you keep these items in the refrigerator, an out-of-range temperature may affect efficacy. Please take the time to review vaccine storage and handling procedures with staff. MIP staff can visit your site to review these procedures. If you are interested in technical assistance, or if you have questions regarding vaccine storage and handling, please contact the MIP's Vaccine Management Unit at (617) 983-6828.

Please take the time to ensure the following in your office:

- Each vaccine storage refrigerator should have a calibrated product temperature thermometer.
- The storage temperature range for refrigerated vaccines (all currently distributed vaccines except varicella) **must be 35°F to 46°F (2°C to 8°C).**
- The temperature log must be checked at the beginning and end of each day.
- Check temperature logs for prior months for temperatures that are out of range.
- If temperatures are ever out of range (too low or too high), call the MIP's Vaccine Management Unit at (617) 983-6828.

Immunization

Please Remember Disease Reporting!!! Massachusetts Immunization Program (MIP) Reminds Providers to Report: Varicella (Chickenpox)

- Currently, providers are required to report the total number of cases of varicella seen in their practice by telephone or reporting card. The widespread use of varicella vaccine is having a dramatic impact on varicella incidence and it is becoming increasingly important to monitor any changes in the epidemiology of this disease. The MIP would like to remind providers to continue to report aggregate numbers of all cases of varicella, either seen in your office or diagnosed by telephone, to your local board of health.
- Beginning in 2001, the MIP will be asking you to report aggregate numbers of cases of varicella by age group, on a monthly basis. We are developing a special reporting form, with age group tables, for this purpose. At some time in the future, when the numbers of cases are more manageable, individual case investigation will be instituted.
- Please notify your local board of health and the MIP (617-983-6800) immediately about any unusual or high-risk case(s), outbreaks, or settings, so that we can assist with control measures. Examples include: 1) case(s) with unusual presentations or severe complications (including invasive group A streptococcal infection, pneumonia, hospitalization, death), 2) immunocompromised case(s), 3) outbreaks involving adolescents and adults, 4) outbreaks among vaccinated populations (these may point to improper storage and handling of vaccine), 5) large outbreaks, 6) outbreaks in healthcare settings, 7) outbreaks in child care centers with infants, or 8) outbreaks in other high-risk institutional settings.

Update On Thimerosal in MIP Supplied Vaccines

On June 22, 2000 the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the United States Public Health Service (PHS) released a Joint Statement that reviewed the significant progress being made in removing thimerosal from childhood vaccines and the results of studies of a potential relationship between exposure to mercury in vaccines containing thimerosal and health effects. (http://www.cdc.gov/nip/vacsafe/concerns/thimerosal/joint_statement_00.htm)

As outlined in the Joint Statement, research into the potential health effects of thimerosal in vaccines is on going. The ACIP convened expert panels to review the data on 17 health outcomes in areas of renal function and neurological development. They have been unable to find any convincing evidence of harm caused by the low levels of thimerosal in vaccines. Therefore the Joint Statement reaffirms that use of any Hib or DTaP vaccine should continue according to the currently recommended schedule. Please note that current ACIP guidance also recommends that DTaP vaccine series be completed preferably with the same formulation.

The status of the Massachusetts Immunization Program's (MIP) vaccine supply is consistent with the nationwide progress on thimerosal reduction as outlined in the Joint Statement.

- All Hib and hepatitis B vaccines currently distributed by the MIP for pediatric immunization are thimerosal-free.
- The overall reduction in exposure to ethylmercury from the routine infant immunization schedule in the first year of life is 60% from 187.5 mcg to 75 mcg.
- The DTaP formulation that the MIP has consistently been distributing since 1996 is anticipated to be thimerosal-free during the first quarter of 2001 and was recently licensed for use for all 5 doses in the DTaP series. Based on current recommendations from the joint Committee on Vaccine Purchasing Strategies of the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) and the Massachusetts Immunization Action Partnership (MIAP), the MIP will be maintaining the distribution of the current DTaP formulation, Aventis Pasteur's Tripedia™, until at least the first quarter of 2001.

Save the dates

The Eighth Annual Ounce of Prevention Conference

"Celebrating Strengths, Challenging Disparities: Reweaving the Healthy Community" - March 14 and 15, 2001, Royal Plaza Conference Center, Marlboro, MA. For more information, contact Michael Coughlin, MDPH - (617) 624-5275.

CDC/NIP Satellite Presentations: Proposed 2001 Dates

Epidemiology and Prevention of Vaccine Preventable Diseases: March 15, 22, 29 and April 5 - 11:30 AM to 4:30 PM each date. State Lab Institute, Jamaica Plain, MA.

Annual Immunization Update: September 20 - 8:00 AM to 4:00 PM. State Lab Institute, Jamaica Plain, MA.

International Travel Vaccines: December 6. State Lab Institute, Jamaica Plain, MA.

For more information on any of the satellite courses, please contact Walt LaSota at (617) 983-6834.

You be the epi

You be the epi

The director of health services at a college campus calls you to report a case of meningococcal meningitis in a student. *Neisseria meningitidis* was cultured from the student's cerebrospinal fluid. The student is a freshman female who resides on-campus in a shared dormitory room. How should you proceed?

Neisseria meningitidis is a bacterium carried in the nose and throats of 5 to 20% of the general population and a very small percentage of those exposed to carriers may develop an invasive infection, such as meningitis. Since *N. meningitidis* is spread through nasal/oral secretions, and close contacts of an invasive case are known to be at an increased risk for invasive infection, identification and chemoprophylaxis of a case's close contacts are necessary. Close contacts include household contacts (e.g., the case's roommate) and any other persons who shared saliva/respiratory secretions with the case through sharing food, beverages, cigarettes or close proximity to coughing/sneezing for extended periods of time, during the two weeks prior to the case's onset of illness. When evaluating the case's close contacts, one should consider participation in activities such as team sports, other extracurricular activities or parties. If the case is not able to provide information regarding his/her activities, enlist the assistance of the case's friends/roommate(s) to recount the case's activities in the two weeks prior to onset of illness. All close contacts of the case should be referred to healthcare providers or student health services for chemoprophylaxis. If a case contact has a history of vaccination with meningococcal vaccine, chemoprophylaxis is still necessary since the vaccine is not effective against all serogroups of the bacteria and will not eliminate the contact from being a carrier and spreading the bacteria to others who are not protected by vaccine. All students should also be made aware of the signs and symptoms suggestive of meningococcal meningitis and encouraged to seek medical attention if they become symptomatic. Surveillance for additional cases of invasive meningococcal disease should continue for three weeks after the initial case.

Recent studies have shown that college students (specifically, college freshman living in a dormitory setting) may have an increased risk of invasive infection with *N. meningitidis*. College freshmen who want to reduce their risk of meningococcal disease may choose to be vaccinated with meningococcal vaccine. All college students and their parents should talk to their healthcare providers and/or student health services about meningococcal disease, the vaccine and the specific circumstances of the students.

Summary of invasive meningococcal disease case follow-up:

1. Confirm the diagnosis: Culture confirmation of *N. meningitidis* from CSF.
2. Identify close contacts for prophylaxis: Evaluate the following persons/activities to identify close contacts (i.e., identify those persons who shared saliva with the case through sharing food, beverages, cigarettes etc.)

- Roommate(s) (possibly dormates depending on the structure and environment of the dormitory)
 - Sexual Partner(s)
 - Close friend(s)
 - Sports team(s)
 - Extracurricular activities (clubs)
 - Parties
 - Workplace
3. Notify close contacts and refer them to their healthcare providers or student health services for chemoprophylaxis. On occasion, a general announcement may have to be posted to identify those at risk. For example, if the case attended a large party with many persons sharing food and beverages the day before her onset of illness, a general campus-wide announcement may be necessary. The announcement should identify the party date, time and place and refer those who attended and who may have shared food and/or beverages to their healthcare providers or student health services for chemoprophylaxis.
 4. Provide general information on the signs and symptoms of meningitis to all students and continue surveillance for additional cases for 3 weeks.
 5. Provide information on meningococcal vaccine to all students.



Tularemia continued from page 2 ...

making them aware of the situation and how they could best protect themselves.

On September 6th, CDC EIS officers returned to Martha's Vineyard where they again interviewed cases and physicians and collected a variety of environmental samples. A case-control study was initiated to determine what exposures were associated with tularemia infection. By the end of September, all confirmed cases and 100 randomly selected controls had been surveyed about outdoor activities and potential exposures. Data collected from these surveys are currently being analyzed.

As of October 20th, fifteen confirmed cases of tularemia among full-time or part-time Martha's Vineyard residents have been reported to MDPH. The majority of these cases have been in men (86%) over the age of forty (64%). Eight of fourteen (57%) confirmed cases are involved in outdoor occupations.

Refugee and Immigrant Health

Understanding and Addressing Disparities in Health Status in Newcomer Communities

Racial and ethnic disparities in health status are complex in terms of cause, as are community, health system, and public response to address the. REACH 2010, a 5-year demonstration project, is part of the President's Race Initiative and Goal for 2010 to eliminate disparities in health status experienced by racial and ethnic minorities in six priority areas: infant mortality, deficits in breast and cervical cancer screening and management, cardiovascular diseases, diabetes, HIV/AIDS, and child and/or adult immunizations. REACH 2010 projects are collaborative in nature and designed to foster community mobilization in geographically defined minority populations.

Four of the 32 projects funded for Phase I are in Massachusetts. The lead agencies and focus areas are: Boston Public Health Commission (breast and cervical cancer among women of African descent), Center for Community Health Education and Research, CCHER, (HIV/AIDS among Haitians in Greater Boston), Greater Lawrence Family Health Center (diabetes and associated cardiovascular disease among Latinos), and Lowell Community Health Center (cardiovascular disease and diabetes among Cambodians). Year one activities have focused on building coalitions, collecting and analyzing local data, and developing community action plans that will guide the work during the four-year Phase II. While two of the Massachusetts projects are particularly focused on refugee and immigrant communities, each of the four embraces and involves newcomers.

A common theme in the Massachusetts projects has revolved around data – the limitations of current data and the need to collect local, community-specific data. Information was collected from existing data sources (such as surveillance, vital statistics, and hospital discharges), as well as clinic records, focus groups, key informant interviews, provider surveys, and community surveys. Among the findings are: whether from Haiti, Cambodia, the Dominican Republic or Somalia, individuals at risk for poor health status often have health beliefs relative to causation and healing that differ from the biomedical model, have limited access to health information, have limited knowledge of the health system, and have limited experience with preventive care. Fear and stigma were reasons one may not be in care. The health systems, themselves, were identified as presenting numerous barriers to care, including poor language accessibility, poor cultural accessibility, lack of diversity, low levels of insurance coverage, poor transportation and, perhaps most profound, histories of institutional racism and low levels of community trust.

The coalitions' community action plans are multi-faceted in addressing disparities. Each is grounded in the community and, as such, builds on the strengths of the community, is culturally and linguistically appropriate, and takes a holistic approach to the per-

son and the community. CCHER will utilize a variety of approaches to target Haitian men, women and youth as well as potential agents of change within the community, such as faith-based leaders, media and other formal and informal leaders. Haitian agencies will play a critical role in the delivery of activities. In Lowell, partner agencies will work to increase language and cultural accessibility to the health system, increase community awareness and utilization of health and emergency services, and provide health screenings, as well as individual and group support to Cambodians with cardiovascular disease. The Lawrence plan aims to stimulate a new sense of individual and community empowerment to decrease risk factors, improve health care, and improve health outcomes through use of multiple mechanisms such as coalitions, intergenerational exercise programs for Latina women, peer groups, churches, and children's education. Mini-grant programs will promote grass-roots involvement.

In early October, the Centers for Disease Control and Prevention announced the Phase II awards. The four Massachusetts projects were approved and funded and will now begin implementing their community action plans.

Building Healthy Communities Together Conference

Building Healthy Communities Together, a conference jointly sponsored by the Massachusetts Office for Refugees and Immigrants (ORI), Massachusetts Department of Public Health (DPH), and Massachusetts Public Health Association (MPHA), was held on October 4, 2000. The purpose of the conference was to provide an opportunity to enhance understanding of public health issues and to inform organizations and agencies providing services to refugee and immigrant communities about public health programs and initiatives. Approximately 130 persons attended with over half from community organizations, including refugee-organized and directed mutual assistance associations, community-based organization serving newcomers, refugee resettlement agencies, and community health centers.

Hortensia Amaro, Ph.D., Professor of Social and Behavioral Sciences, Boston University School of Public Health, was the keynote speaker. In addition to presenting background data on newcomers, she challenged participants to develop recommendations in several areas: data, language access, health insurance coverage, provider expertise, public perceptions about newcomers, and certification for foreign-trained professionals.

Six panelists described public health programs focused on tobacco, communicable diseases, domestic violence, and environmental health and their relevance for refugees and immigrants.

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Metro West Regional Clinical Services Highlight

Tuberculosis Surveillance Area (TSA) 2

TSA Nurse: Jo-Ann Keegan, R.N., M.S.N.

In 1999, 47 TB cases of tuberculosis were verified in the MetroWest region. The TB Division funds 3 TB clinics in the MetroWest region. This issue's highlighted clinic, managed by the Cambridge Health Alliance, is located at Cambridge Hospital. All residents in Cambridge and Somerville can receive TB-related services at the clinic. There were 13 verified TB cases in these two cities in 1999. Drs. Edward Nardell and David Bor head a team of pulmonary and ID specialists who see the clinic patients. Cambridge Health Department nurses, experienced in TB control, also staff the clinic. The clinic is accessible to the diverse, at-risk population it serves and the TB clinic team speaks a variety of languages including Haitian Creole, Portuguese and Spanish. Recently, the clinic moved into its newly renovated space in the Outpatient Clinical Specialties area on the third floor of the hospital. The new clinic hours are Mondays 2:00pm to 6:00pm and Thursdays 8:00am to 11:00am.

TB Community-Based Prevention Project: The Division of TB Prevention and Control initiated a community-based TB prevention project in Cambridge. The project focuses on increasing targeted testing and prevention of tuberculosis in the Haitian community. A multi-media public service program is being developed, in collaboration with the Cambridge Health Alliance, to increase awareness and the need for testing people at risk. The TB Division looks forward to continuing its partnership with the leaders in the Haitian community and the Cambridge Health Alliance.

Metro West Regional Clinical Services Address Change!

The TB clinic formerly located at St. Elizabeth's Medical Center has been relocated to the Brighton Marine Health Center at 77 Warren Street. The clinic serves all patients needing TB-related services that reside in the Allston-Brighton, Newton, Brookline and Watertown areas. The clinic is held every Monday from 12 noon to 4 PM. Call 617-562-5385 for appointments.

Employee changes

- ◆ Shameer Poonja is the Director of TB Prevention Services, which includes the Community-Based TB Prevention Project.
- ◆ Joe Pike is the epidemiologist on the TB Prevention Team. He has worked on several TB research projects for the Division.
- ◆ Kelly Letendre is the administrative assistant in the Southeast Regional TB office.
- ◆ Robert Suruki, is now working with Susan Logan on the Contact Investigation Project. He was the epidemiologist for the RFLP/Cluster Project.
- ◆ Shereese Davis is Biometrician for the surveillance and epidemiology unit.
- ◆ Joe DeCinti has been promoted to Director of Operations.

- ◆ Linda Singleton has been promoted to Assistant Division Director.

Save the date

The next Regional TB Update will be at the Lahey Clinic in Burlington on Thursday, January 25, 2001.

Announcement

New recommendations entitled, "Tuberculosis and Managed Care: A Guide for Massachusetts Providers" have been prepared by the Medical Advisory Committee for the Elimination of Tuberculosis. These recommendations are based on the new guidelines for targeted testing and treatment for latent TB infection published this year by the Centers for Disease Control and Prevention (CDC) and the American Thoracic Society (ATS) in *The American Journal of Respiratory and Critical Care Medicine* 161:S221-247. These new recommendations and guidelines will be mailed to Massachusetts providers in early 2001.

The following patient and community education brochures are now available:

- ◆ "Someone I Know has TB" developed for patients who are **contacts** to active TB cases.
- ◆ "Your TB Test" developed for patients that receive tuberculin skin tests - The brochure is also available in Chinese, French and Spanish.

CD UPDATE

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Building Healthy Communities

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Janet L. Scott-Harris, director of minority health for the federal Department of Health and Human Services Region I, summarized three recurring themes from the panel: lack of data specific to newcomer populations and limitations of existing data, the lack of cultural specificity and competency in programs, and language barriers to information and services.

Afternoon breakout sessions offered opportunity for further exploration of the morning health topics – tobacco, communicable diseases, domestic violence, and environmental health. Representatives from newcomer community agencies opened the sessions, presenting overviews of their programs, discussing community beliefs, issues, successes and challenges. Successes were attributed to strong community collaborations, messages tailored to specific age groups and using various ethnic media, and working through the home and the family. Among the continuing challenges that were noted in all sessions were inadequate funding, addressing beliefs from home countries, changes in family dynamics upon arriving to the U.S., lack of health education materials, and the heightened challenge of working with persons without U.S. citizenship given the increasingly restrictive federal laws.

The conference successfully set the stage for future collaborations and information exchange.

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